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Title: Total Elbow Arthroplasty: A Prospective Clinical Outcome Study of Discovery Elbow System with a 4-Year Mean Follow-Up

Running Title: Clinical Outcome of the Discovery Elbow

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Total Elbow Arthroplasty: A Prospective Clinical Outcome Study of Discovery Elbow System with a 4-Year Mean Follow-Up

Abstract

Background: Total elbow arthroplasty (TEA) is increasingly used for the treatment of advanced elbow conditions to reduce pain and improve function. However, TEA is still associated with a higher complication rate compared to the total hip and knee arthroplasty despite advances in the design and surgical techniques. This prospective clinical study reports the outcome of the Discovery Elbow System (Biomet Inc., Warsaw IN, USA) system which has been in clinical use in the UK since 2003.

Methods: The study included a total of 100 Discovery elbows (April 2003 to January 2010) with a minimum 2-year follow-up including 75 primary and 25 revisions (60 % females and 40% males; mean age, 62 years). Outcome was assessed by means of Liverpool Elbow Score, pain experience, patient satisfaction, range of movement, and radiographic imaging.

Results: Mean follow-up was 48.5 months (range: 24-108 months). Liverpool Elbow Score improved from 3.79 to 6.36 (P<.001). Pain-free patients were substantially increased form 7% preoperatively to 64% at the final follow-up. Patient satisfaction rate was over 90%. The arc of flexion-extension and pronation-supination increased from 72º to 93º and from 86º to 111º, respectively (P<.001). Major post-operative complications included deep infection (2%), progressive aseptic loosening requiring revision (primary, 5%; revision 12%), persistent ulnar neuropathy (3%), and periprosthetic fracture (primary, 6.8%; revision, 8%).

Conclusion: Discovery elbow resulted in improved function, reduced pain, and high patient satisfaction. Long-term results are required for assessing the survivorship of this system.

Keywords: Total Elbow Arthroplasty; Discovery Elbow; Clinical Outcome; Elbow Prostheses.

Level of Evidence: Level III

BACKGROUND

Total elbow arthroplasty (TEA) has increasingly become a popular reconstructive procedure due to improved surgical techniques, advanced implant designs, and enhanced clinical outcomes.[39] The modern era of TEA began in the late 1970s when the prosthetic design evolved following several key developments: the use of high-density polyethylene as a bearing surface to metal, the use of methyl methacrylate bone cement, and the implementation of biomechanical science to reproduce normal joint kinematics.[7] Modern TEA implants are designed as linked or unlinked. Linked implants are coupled together through a hinge allowing for some degrees of laxity in the medial, lateral, and rotational planes consistent with normal elbow kinematics. A "sloppy hinge," design is associated with a reduced rate of aseptic loosening and instability of the articulation.[34] Unlinked implants are not mechanically coupled and mostly rely on matching shapes of the bearing surfaces, adequate bone stock, and, the integrity of capsular and ligamentous structures.[5,7] Unlinked designs have been associated with higher rate of instability as their stability mainly depends on their geometry and surrounding soft tissues (ligaments and bone stock) rather than the intrinsic constraint of the articulation.[5]

The use of unlinked prostheses may be preferred when there is less bone or articular destruction and in younger patients who may need later revision surgery. To the other hand, the increased stability of the linked implants has expanded their use in conditions with increased bone destruction and ligamentous incompetency such as advanced stages of rheumatoid arthritis, posttraumatic and degenerative osteoarthritis, and complex distal humerus and intra-articular fractures (particularly in elderly patients).[5,7,22]

Despite considerable developments in the prosthetic design, TEA has been associated with a high rate of complications, ranging from 20% to 45%, compared to other main total joint (hip

and knee) replacements[15,27,41] potentially because of the difficulty of surgical procedure in a complex joint with minimal soft tissue support.[10] Gschwend et al,[15] reviewed the literature and reported an overall complication rate of up to 43% including aseptic loosening, infections, ulnar nerve complications, instability, disassembly, dislocation, subluxation, intraoperative fractures, fractures of the prosthesis, implant loosening, periprosthetic fracture, triceps insufficiency, and ectopic bone formation. In another review, Little et al,[27] reported an overall complication rate of 14%-80% with a median rate of 33%.

In terms of more specific complications, polyethylene bushing failure/wear [16,25,27,34] and hinge failure[14, 25] have been associated with the earlier designs of the linked prostheses. While linked, semiconstrained prostheses with a "sloppy" hinge linkage system were designed to protect against loosening and to allow for their use in the presence of significant bone or ligamentous deficiency;[17] the earlier designs have been associated with a high rate of bushing failure (14% to 47%) because of using polyethylene-type bushings which can result in particulate polyethylene-induced synovitis, osteolysis, and implant loosening.[14,17,26,30,44] In addition to bushing failure, other types of mechanical failures including disassembly and failure of the hinge locking mechanism have been described in relation to commonly used semiconstrained linked prostheses such as the Coonrad-Morrey[12,37,44] and GSBIII.[15]

The Discovery ™ Elbow System (Biomet Inc, Warsaw, IN, USA) was designed to address specific complications associated with the earlier designs by providing more accurate positioning of the elbow flexion/extension axis; ensuring stability without employing a true hinge; distributing contact forces over large condylar surfaces; and preserving the ulnar collateral ligament.[17,18] Furthermore, assembling chrome cobalt condyles that connect the humeral and ulnar components after cementing preserves the humeral condyles. These design characteristics is expected to reduce the rate of polyethylene bushing wear, reinforce anatomic stem design, restore natural elbow joint biomechanics, and produce a hinge that

could be easily revised.[17] The Discovery elbow has been in clinical use in the UK since 2003. The structural specifications and design rationale of the system have been described in full details by Hastings and Theng[19] and Hastings.[17]

This study aimed to 1) report functional and radiological outcome of the Discovery elbow in a large series of primary and revision TEAs with various elbow pathologies; and 2) compare the clinical outcome and complications with published literature on other prostheses.

PATIENTS AND METHODS

One hundred Discovery elbows with a minimum 2-year follow-up were included in the study. All TEAs were performed in a single centre by the same surgeon (April 2003 to January 2010). The technical properties of the prosthetic system and surgical technique have been described in full details by Hastings et al.[17]

The mean age of patients (females, 60 %; males, 40%) was 62 years (range: 22-86), weight 71.8kg (±18.3), and height 166 (±12.5). The mean follow-up period was 48.5 months (range: 24-108 months). Inclusion criteria were advanced arthritis unresponsive to non-operative management, acute distal humerus fracture and revision for loosening of other elbow prostheses in skeletally mature patients (>18 years old). Exclusion criteria included systematic metabolic diseases affecting the bone formation and active infection. The main underlying pathologies (diagnoses) are outlined in Table1. Primary and revision TEA comprised 75% and 25% of the cases, respectively. Study received approval from a local research ethics committee and all patients gave informed consent prior to the surgery.

FOLLOW UP ASSESSMENT

Functional Outcome

Main clinical information and data including underlying pathology (primary diagnosis), type of TEA (primary, revision), follow-up period, pain experience ('No Pain', 'Mild Pain', 'Moderate Pain', 'Severe Pain'), patient satisfaction ('Not Satisfied', 'Satisfied', 'Somewhat Satisfied', 'Very Satisfied'), range of movement (flexion/extension of the elbow and pronation/supination of the forearm), and complications were collected using a purpose-designed elbow arthroplasty proforma. A validated elbow-specific score, Liverpool Elbow Score (LES), was used for functional assessment (Appendix1).[35,42] The patient-rated section of the LES has good correlation to the Mayo Elbow Performance Score (MEPS) and has been

recommended as an outcome measure for evaluating the results of TEA.[4] The AO handbook for Musculoskeletal Outcomes Measures and Instruments rated this score as a superior quality outcome assessment tool compared to MEPS.[39] A score of 0 and 10 indicate worst and best outcome, respectively.

Radiographic assessment

Radiographic assessment involved preoperative and post-operative (immediately post-operative; 3, 6, 12 months post-operative; and then annual) anterioposterior and lateral plain x-rays (Figure.1). Imaging was reviewed for humeral and ulnar stem alignment in sagittal and coronal planes, aseptic loosening, periprosthetic fracture, dislocation, and hypertropic ossification. Imaging assessment pattern followed the principles explained in a recent comprehensive radiographic review of TEA.[31] For assessing the component alignment, angles between the axis of the shaft of humerus and the stem of the humeral component and between the axis of the shaft of ulna bone and the stem of the ulnar component were measured in the early post- operative x-rays.[13] A malalignment of >10º was considered as significant.[11,13,40] Periprosthetic fracture was evaluated based on Mayo Classification System (Figure.2).[30] Radiographic and clinical assessments were performed by independent assessors other than the principal surgeon to eliminate the possibility of information bias.

Data Analysis

Continuous and descriptive data are reported as mean and standard deviation (Mean $\pm$ SD) and 95% confidence interval. Categorical data are described using proportion and percentage. Paired Student *t* test or ANOVA were used to compare the preoperative LES and ROM with those at the final follow-up for the entire patient group and according to underlying pathology (primary diagnosis) and type of TER (primary, revision), as appropriate. The level of

significance was set at 5 % ($p < 0.05$). SPSS package (IBM SPSS Statistics for Windows, Version 21.0. Armonk, NY: IBM Corp.) was used for data analysis.

RESULTS

Functional Outcome Results

Preoperatively, 61% and 21% of patients experienced severe and moderate pain, respectively which was then reduced to 11% and 14% post-operatively. The percentage of pain-free patients was substantially increased form 7% preoperatively to 64% at the final post-operative follow-up. In terms of patient satisfaction, 63%, 8%, and 23% of patients were classified as 'Very Satisfied', 'Somewhat Satisfied', and 'Satisfied', respectively. Only 6% (primary, 5%; revision, 1%) remained unsatisfied with the outcome.

The mean preoperative and final follow-up LES were 3.79 (±1.71) and 6.36 (±1.85), respectively which highlighted a significant improvement ($p< 0.001$). Similar improvements were observed for all main pathology groups (inflammatory and non-inflammatory arthritis, and Fracture), however, LES improvement was significantly higher in the primary (6.41±17) compared to revision TEA (5.78±14) ($p<0.05$). Table 2 summarises the results of ROM for flexion and extension of the elbow and pronation and supination of the forearm for entire patient group and according to the main diagnoses. A significant improvement was noted for all measured movements except elbow extension (extension deficit). Despite lack of improvement in the mean elbow extension, flexion-extension arc was significantly improved. ROM improvements in revision TEA were comparable with those of primary TEA.

Radiographic Assessment Results

Pre-operative and post-operative follow-up (immediately post-op; 3, 6, 12 months post-op; annual, and the final follow-up) x-rays of 88 TEAs (88%) (primary, 70; revision, 18) were available for review. Table3 presents the degree of alignment of humeral and ulnar components (stems) in both sagittal and coronal planes. Around 90% of the evaluated TEAs presented with a good alignment (<5º) for both components in both planes. A significant

malalignment (>10º) was seen in one primary TEA elbow; however it was not associated with early loosening.

The overall incidence of periprosthetic fracture was 14.8% (primary, 6.8%; revision, 8%) involving humeral condyles and olecranon in 9.1% and 5.7% of elbows, respectively. All fractures were classified as Mayo Type 1 and managed conservatively. Hypertropic ossification occurred in 6.8% of TEAs (primary, 5.7%; revision, 1.1%). Areas of non-progressive lucency were noted around the bone-cement interface of 10 primary and seven revision TEAs without any further progression.

Marked Complications

Marked complications including deep infection, osteolysis/loosening, prosthetic failure, and permanent ulnar neuropathy occurred in approximately 16% of TEAs of which 13% required further surgical management. Marked osteolysis around the humeral component was observed in two of primary and one of revision TEAs; but the prosthesis remained stable with no need for revision. Four primary TEAs developed significant osteolysis and required revision of either humeral component (n=3) or both humeral and ulnar components (n=1). Three revision TEAs developed progressive loosening of both humeral and ulnar components; two underwent 2nd revision and one is awaiting revision. Deep infection occurred in 2 cases (both required a 2-stage revision), persistent ulnar neuropathy in 3 cases (managed with nerve decompression and transposition), and prosthetic failure in 1 case. The prosthetic failure was of non-traumatic nature and occurred due to the failure of the screws at the linkage mechanism causing the dissociation of the condyle from main components. This prosthetic failure was managed by revision surgery and change of the screws. The cause of this failure was believed to be related to the primary design of the prosthesis which was later improved.

DISCUSSION

Despite recent developments in the design of elbow prostheses, advances in surgical techniques, and marked improvements in pain and function, TEA is still associated with high complication and revision rates compared to hip and knee arthroplasty.[7,41,43] This high complication rate is partly related to the anatomical characteristics of the elbow such as insufficient bone stock for implantation and lack of strong supporting soft tissue.[3,24]

Elbow prostheses have been used for decades in linked (e.g. Coonrad-Morrey, GSB III, Triaxial, Discovery System) and unlinked (e.g. Kudo, Souter-Strathclyde, IBP) or both linked and unlinked (e.g. Acclaim) modes. The Discovery elbow is a linked prosthesis with a design that mimics the anatomical characteristics and kinematics of the elbow joint. The present study reports the clinical outcome of TEA with this system over a 4-year mean follow-up and compares the results with other reports. However, direct comparison of clinical outcomes amongst different TEA implants is a challenging task because of heterogeneity in reporting methods of function, pain experience, patient satisfaction, and radiographic assessment.

Pain relief is one of the prime benefits following any joint arthroplasty. In the present study, around 64% of cases had no pain at the final follow-up. The majority of the studies on TEA have used percentage of patients with no pain or mild pain as measure of success of the procedure. By that standard, 78% of our cases had either no pain or only mild pain at final follow-up. The percentage of patients with no pain or mild pain after undergoing Acclaim,[6] Souter-Strathclyde,[33] GSB III[15,23,36] and Coonrad-Morrey[27,38] have been reported as 64%, 67%, 50–92% and 60-100%, respectively. Overall the patient satisfaction rate for our series was 94% with 63% of patients reporting maximal satisfaction (Very Satisfied). A study of different linked prostheses (11 elbows) reported a 73% satisfaction rate.[40] In a study of 51 elbows using the Coonrad-Morrey prosthesis, Hildebrand et al,[20] reported patient satisfaction

of 9.2/10 in inflammatory arthritis and 8.6/10 in posttraumatic arthritis. A recent study of Discovery Elbow replacement patients in 46 elbows reported a patient satisfaction rate of 9.1/10 based on modified American Shoulder and Elbow Surgeons elbow score.[18] The study, however, involved only primary TEAs with majority of them (50%) diagnosed with RA.

Functional capacity was markedly improved in our cohort of patients according to the LES which integrates both patient self-evaluation and clinician's assessments. The LES is a more recently developed elbow-specific outcome measure and less frequently used compared to the MEPS in TEA studies. However, it has high responsiveness to the changes following TEA[42] and scored higher (9 of 10) than MEPS (6 of 10) against the strength criteria of an outcome measure (Content, Methodology, and Clinical Utility) outlined in the AO Handbook Musculoskeletal Outcomes Measures and Instruments.[39] Furthermore, a strong correlation exists between LES and MEPS[4] indicating that marked improvement found for the LES in the present study are in line with those reported for other prostheses.[2,25,27,28,32] The mean improvement in flexion-extension arc in our TEA series was 21º. Based on systematic reviews of semiconstrained linked and unlinked TEA prostheses, the average improvement in flexion-extension arc ranged between 12º-39º with a weighted improvement of 26°.[27,41] According to individual studies, the mean improvement in flexion-extension arc with Acclaim,[6] Souter-Strathclyde,[33] GSB III,[21,23] and Coonrad-Morrey prostheses[38] were 23º, 15º, 19º-33º and 17º-26º, respectively. A recent study of 46 Discovery elbows reported an improvement of 40º in flexion-extension arc.[18] The mean improvement in pronation-supination arc in our series was 25º. This movement arc has been reported as 21º-28º for Coonrad-Morrey prosthesis[38] and 31º-67º for GSB III prosthesis.[21,23] Hastings et al,[18] reported an increase of 29º in pronation-supination arc with Discovery elbow. It has to be taken into consideration that our reported results combine both primary and revision TEAs.

Deep infection remains the most worrying complication with a rate of around 4% infection reported in longer-term TEA studies.[9,27] The overall incidence of deep infection in our series was 2%. The incidence of deep infection with GSB III TEA has varied between 4%-11%.[15,23,36] Studies on Coonrad-Morrey TEA have reported an infection incidence rate of 6%-8%.[20,27] Hastings et al,[18] recently summarised complications for Coonrad-Morrey, GSB III, Solar, and Discovery prostheses in 595 TEA patients (561 primary, 34 revision) and cited the average rate of deep infection as 2.9%.

While rates of aseptic loosening appears to have improved to less than 10%,[42] it remains a major cause of revision following TEA. Progressive aseptic loosening requiring revision occurred in 4 primary (5%) and 3 revision (12%) patients of our series. In primary group, humeral and ulnar components were affected in three and one cases, respectively. In revision group both components were affected. Six of aseptic loosening cases underwent revision surgery with Discovery elbow and remained stable by the time of final follow-up, one case is awaiting revision. This complication has been reported in association with other linked prostheses including Coonrad-Morrey (0%-7%),[1,14,16,20,27] GSB III (4%-29%),[8,15,21,36] and Souter-Strathclyde (up to 31%).[16,25,32] Summarising the complication reports from linked devices, Hastings et al,[18] and Kelly et al,[23] have cited the average rate of primary aseptic loosening as 8.9% and 4%-50%, respectively. In a recently published study of 46 Discovery elbow cases, aseptic loosening of the humeral component developed in 1 patient (2.2%) without need to revision.[18] The study however, reported revision of a severe loosening case of humeral component together with associated condyles and bearing in another patient who did not meet study population inclusion criteria. Another study of Discovery elbow (18 cases) reported an aseptic loosening (5.6%) due to inadequate cementing of the ulnar component 17 months following TEA which required revision surgery.[10]

The overall rate of periprosthetic fracture was 14.8% (primary, 6.8%; revision, 8%) in the present study. All fractures were classified as Mayo Type 1 and required conservative management. The incidence of periprosthetic fractures with Acclaim,[6] GSB III,[21,36] and Coonrad-Morrey[20] has been reported as 36%, 16%-21%, and 23%, respectively.

Incidence of persistent ulnar neuropathy requiring surgical intervention was 3% in our series. Ulnar neuropathy is seen more commonly in rheumatoid arthritis as close proximity of the nerve to the elbow joint can lead to inflammation of the nerve due to synovitis in the nearby elbow joint and valgus instability can lead to stretching of the ulnar nerve.[29] The incidence rate of ulnar neuropathy with GSB III, Coonrad-Morrey, and Acclaim has been reported as 11%-14%,[8,23] 12%-26%,[1,20] and 8%,[6] respectively. Summarising the complications of TEA in 595 patients, Hastings et al,[18] cited a rate of 4.4% for ulnar neuropathy.

The present study provided comprehensive prospective clinical outcome data on for the Discovery elbow arthroplasty. The study included a large cohort of primary and revision TEAs which reduced the scope of selection bias. Furthermore, performing clinical and radiographic assessments by independent assessors decreased the possibility of information bias. There were, however, some limitations to the study. First, study included both primary and revision TEAs which might have some effect on reported outcome results. In order to address this, significant differences between primary and revision TEAs in outcome measures (e.g. LES) and complications rates are highlighted in the paper. Second, study used LES as a key functional assessment tool. This reduced the scope of comparisons with other studies into some extent as based around half of recent outcome reports used MEPS.[27] Hence, MEPS was added into our functional assessment tools a few years ago and being completed in addition to LES for all prospective TEAs. Third, a 4-year mean follow-up provides a relatively

reasonable period for functional outcome report but a longer term follow-up is required for assessing late complications and survivorship of the prosthesis.

CONCLUSION

The results indicate that Discovery elbow is a system viable option for the treatment of advanced inflammatory and non-inflammatory elbow conditions where a TEA is indicated. This was reflected in significant improvements in LES, range of movement, pain experience, and a high patient satisfaction score at a 4-year mean follow-up. The incidence of complications was either comparable or less than that reported for other linked prostheses. We need to wait for the long term results of this prosthesis to assess its survivorship.

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Figure and Table Legends

Figure1. Lateral and anteroposterior x-rays of an elbow with osteoarthritis before (a-b) and 6-year after total elbow arthroplasty with Discovery Elbow (c-d).

Figure2. Graphic illustration of the Mayo Clinic classification system used for describing periprosthetic fractures in elbow arthroplasty. It is important to differentiate between different types of fractures as those affecting the hardware stems (types 2 and 3) will potentially require revision. (Reprinted with permission from RadioGraphics.[31]

Table1. Incidence of diagnoses for primary and revision Total Elbow Arthroplasty (TEA)

Table2. Comparison of the mean (SD) pre- and postoperative elbow and forearm ROM with Discovery Elbow according to main underlying pathologies in all patients (primary and revision)

Table3. Prosthesis alignment in primary and revision Total Elbow Arthroplasty (TEA)

Table1. Incidence of diagnoses for primary and revision Total Elbow Arthroplasty (TEA)

Main Diagnoses and sub-diagnoses	Incidence (%) (n = 100 elbows)
Inflammatory Arthritis	
Rheumatoid Arthritis	54
Juvenile Rheumatoid Arthritis	2
Psoriatic Arthritis	2
Non-Inflammatory Arthritis	
Degenerative Osteoarthritis	17
Traumatic Arthritis	14
Haemophilic Arthropathy	3
Nail–patella syndrome	1
Distal Humerus Fracture (acute and non-union)	7
Total TEA	**100**
Revision TEA	
Inflammatory Arthritis	16
Non-Inflammatory Arthritis	7
Fracture	2
Total	**25**

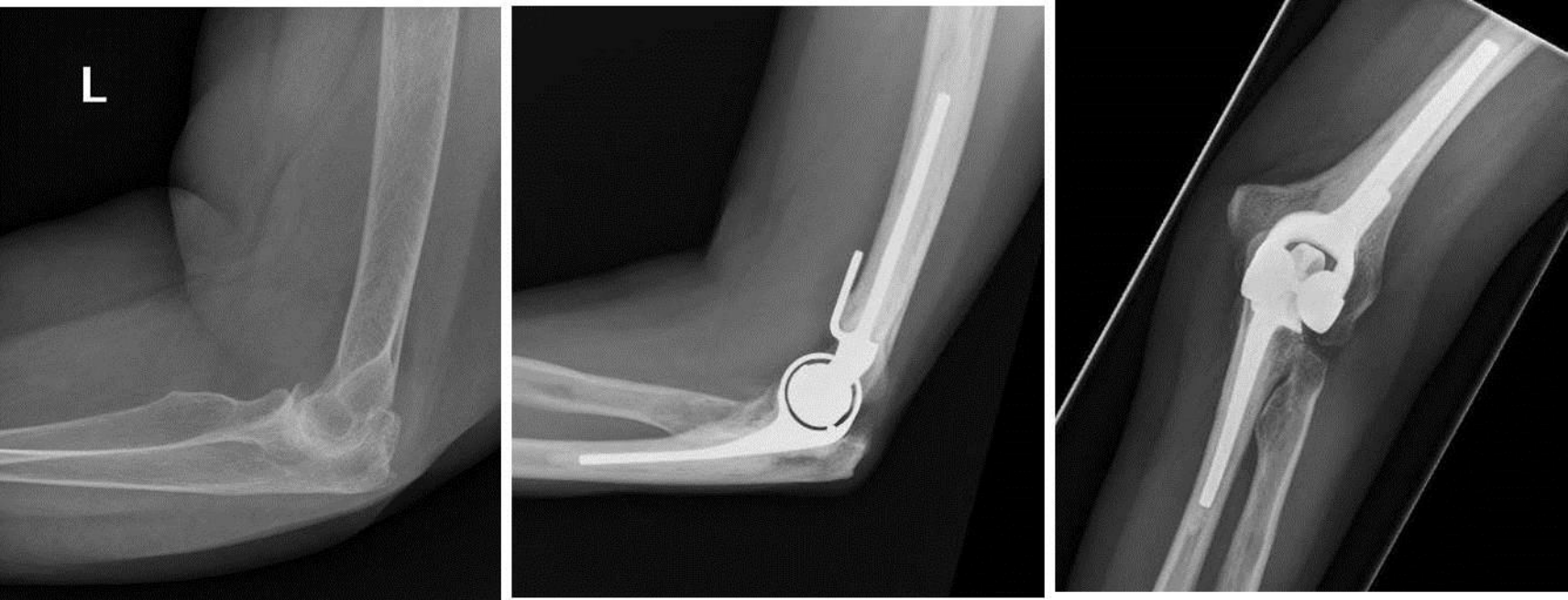
Table2. Comparison of the mean (SD) pre- and postoperative elbow and forearm ROM with Discovery Elbow according to main underlying pathologies in all patients (primary and revision)

Elbow/Forearm ROM	All Patients		Non-Inflammatory (Osteoarthritis)		Inflammatory (Rheumatoid Arthritis)		Fracture	
	Pre-op	Post-op	Pre-op	Post-op	Pre-op	Post-op	Pre-op	Post-op
Flexion	100 (24)	118 (17)**	101 (26)	118 (18) *	100 (20)	117 (16)**	92 (38)	115 (28)
Extension lag	28 (14)	25 (14)	28 (11)	25 (12)	28 (16)	26 (16)	23 (15)	18 (17)
FLX-EXT ARC	72 (28)	93 (27)**	73 (30)	93 (26)*	72 (27)	92 (26)**	87 (33)	97 (44)
Pronation	48 (23)	61 (21)**	49 (25)	64 (18)*	46 (23)	59 (22)*	61 (17)	64 (15)
Supination	38 (26)	50 (25)**	42 (26)	55 (21)*	35 (26)	45 (25)*	52 (23)	51 (29)
PRON-SUP ARC	86 (45)	111 (42)**	91 (48)	119 (35)**	81 (44)	104 (42)*	113 (39)	115 (41)

-SD, Standard Deviation; FLX, Flexion; EXT, Extension; ROM, Range of Motion; Pre-op, Preoperative; Post-op, Postoperative.
-Significant difference at $P \leq .05$ (*) and $P \leq .001$ (**).

Table3. Prosthesis alignment in primary and revision Total Elbow Arthroplasty (TEA)

Degree of Malalignment	Coronal Plane		Sagittal Plane	
	Humerus	**Ulna**	**Humerus**	**Ulna**
PRIMARY TEA				
Less than 5 degrees	61	57	48	63
5-10 degrees	9	13	22	6
More than 10 degrees	0	0	0	1
REVISION TEA				
Less than 5 degrees	16	16	14	17
5-10 degrees	2	2	4	1
More than 10 degrees	0	0	0	0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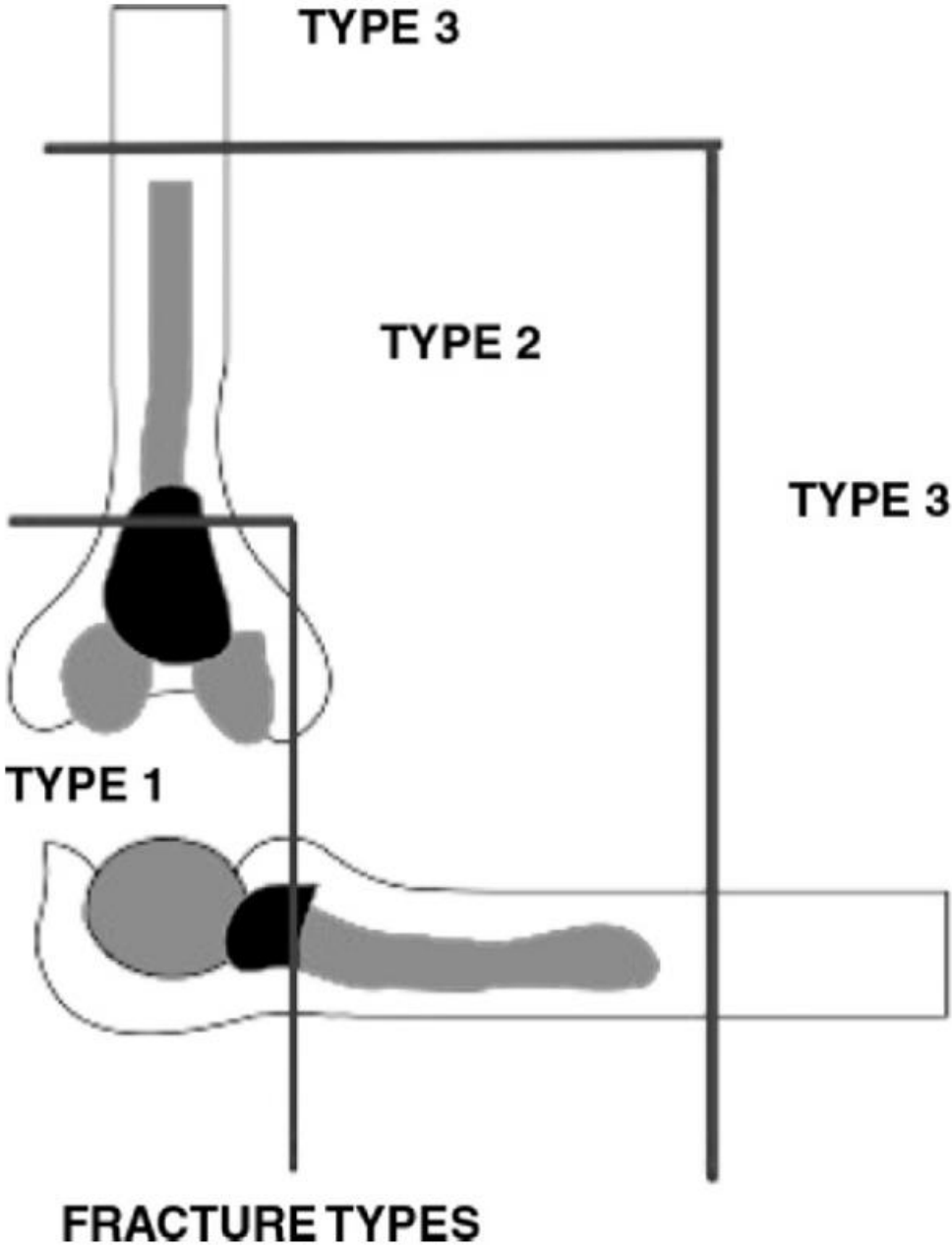

FRACTURE TYPES

Figure and Table Legends

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Table1. Incidence of diagnoses for primary and revision TEA

Table2. Comparison of pre- and postoperative elbow and forearm range of motion with Discovery Elbow according to main underlying pathologies in all patients (primary and revision)

Table3. Prosthesis alignment in primary and revision TEA

Liverpool elbow score

	Score 4	Score 3	Score 2	Score 1	Score 0
Clinical assessment					
1. Flexion	-	>135°	120-135°	90-120°	<90°
2. Extension	-	None	<20°	20-30°	>30°
3. Pronation (add 1 to score if wrist/forearm pathology)	-	-	>50°	50-20°	<20°
4. Supination (add 1 to score if wrist/forearm pathology)	-	-	>50°	50-20°	<20°
5.Strength: average of flexion, extension, pronation and supination	Apparently normal	Complete motion against gravity and some resistance	Complete motion against gravity	Complete motion with gravity eliminated	Absent
6.Ulnar nerve	-	None	Sensory	Motor:no disability	Motor: With disability
Patient-answered question During the past four weeks:					
1. How often have you had to use your other arm to do things normally done by the affected arm?	Never	Once or twice	Sometime	Many times	Every time
2. Has your elbow problem caused you any difficulty in combing your hair?	None	Little	Moderate	Severe	Unable to do
3. Has your elbow problem caused you any difficulty in washing yourself?	None	Little	Moderate	Severe	Unable to do
4. Has your elbow problem caused you any difficulty in feeding yourself?	None	Little	Moderate	Severe	Unable to do
5. Has your elbow problem caused you any difficulty in dressing yourself?	None	Little	Moderate	Severe	Unable to do
6. Has your elbow problem caused you any difficulty in trying to do household activities?	None	Little	Moderate	Severe	Unable to do
7. Has your elbow problem caused you any difficulty in lifting, e.g. a kettle, a milk bottle, groceries?	None	Little	Moderate	Severe	Unable to do
8. How would you describe the pain from this elbow?	None	Little	Moderate	Severe	Unbearable
9. Has your elbow problem affected your sport and leisure activities?	None	Little	Moderate	Severe	Unable to do